Confidential Client Information Form

New Seattle Massage

4519 ½ University Way NE
Seattle WA 98105

Name:____Date of Birth:______________________
Address:____City:__________State:____Zip:________
How may we contact you? Phone:______________(H)______________(W)________________(C)
Email:____ Occupation: ____________________________
Emergency Contact:______________________Phone:_________________________

Your information is used by New Seattle Massage to assure a safe massage, maintain records and appointments, provide you with information about massage and our practice and keep you informed of upcoming promotions and events. If you prefer not to receive promotional information or newsletters, please check the box below and you will not be added to our mailing list. New Seattle Massage does not supply client information to any other company for marketing purposes.

☐ I prefer not to receive NSM newsletters or notice of upcoming promotions or events

How did you hear about us? ____

Have you received massage therapy before?______No______Yes Frequency?______________________________

Have you had any difficulty receiving massage?____

Please list any Surgeries/Accidents/Major Illnesses____

Are you under the care of a physician? ____No ____Yes If yes, what for?__________________________________

Are you currently taking medications? ____No ____Yes If yes, please list:_________________________________

Health History: **For all that apply to you, please mark "C" for current and "P" for past conditions**

____AIDS/HIV+	____Digestive Problems	____Phlebitis
____Allergies	____Disc/Spinal Problems	____Pregnancy
______Scents	____Epilepsy/Seizures	____Rashes
______Oils	____Headaches	____Ringworm
______Lotions	____Heart Ailments	____Sciatica
______Nuts	____Heart Attack	____Stiff Joints
____Anemia	____Herpes Virus (cold sores)	____Strains/Sprains
____Aneurysm	____High Blood Pressure	____Stroke
____Arthritis	____Low Blood Pressure	____TMJ
____Back Pain	____Lymphadema	____Tendonitis/Bursitis
____Broken Bones	____Migraines	____Tumors
____Cancer	____Mental Health Conditions	____Varicose Veins
____Circulation Problems	____Muscle Spasms	____Whiplash
____Diabetes	____Numbness/Tingling	____Other Significant Health Issue

Please read and sign: I give my consent to receive massage therapy for myself or for ________________________ (if under age 14). I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health (or health of minor, if applicable). I agree to give at least 4 hours notice of any cancellations or changes of appointments. If I do not give such notice, I agree to pay a $40 fee, which will go directly to the practitioner for holding the space on her/his schedule. I have received a copy of New Seattle Massage's privacy policy consistent with HIPAA.

____ ____________________________
Client Signature or Parent/Guardian Signature, if Client is a Minor Date